State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: /_/ No limitations /X/ With limitations*

2.a. Outpatient hospital services.

Provided: /_/ No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic WHICH ARE OTHERWISE INCLUDED IN THE STATE PLAN.

Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: /_/ No limitations /X/ With limitations*

~~d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.~~

3. Other laboratory and x-ray services.

Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

1. INPATIENT HOSPITAL SERVICES

The maximum reimbursable length of stay without prior approval for psychiatric services is thirty (30) days. There is no other limitation on number of inpatient hospital days for eligible recipients if services are medically justified. Claims are subject to review for medical necessity.

Limitations

1. Reimbursement for private rooms will be made at the most common semi-private room rate. Special care units are covered if medically justified by the attending physician.

2. Admission for diagnostic purposes is covered only when the diagnostic procedures cannot be performed on an outpatient basis.

3. Chest x-rays and other diagnostic procedures performed as part of the admitting procedure will be covered only when:

   The test is specifically ordered by a physician responsible for the patient's care.

   The test is medically necessary for the diagnosis or treatment of the individual patient's condition.

   The test does not unnecessarily duplicate the same test done on an outpatient basis before admission or one done in connection with a recent admission.

4. Surgical procedures deemed to be appropriately performed on an outpatient basis are not covered as inpatient services unless medical necessity for inpatient admission is documented.

5. Hysterectomies, sterilizations and abortions are covered only when applicable Federal requirements are met.

6. Hospital services in connection with the acquisition of an organ from a living donor for transplant in an eligible recipient are considered as services for the treatment of the recipient and are covered as such, although the donor may or may not be Medicaid eligible.

7. Kidney transplants are covered for recipients with documented end stage renal disease. Prior approval is not required unless the procedure is performed out-of-state.

8. In applying standards to cover organ transplants, similarly situated individuals are treated alike. Any restriction on the facilities or practitioners which may provide such procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State Plan.

TRANSMITTAL 92-04
APPROVED 2-21-92
EFFECTIVE 1-1-92
SUPERSEDES 89-36

Inpatient Hospital Services (cont'd)

9. The maximum reimbursable length of stay without prior approval for psychiatric services is thirty (30) days.

10. Inpatient dialysis services are covered for maintenance dialysis of a patient with end stage renal disease only if the admitting hospital does not have a Hospital-Based Dialysis Facility.

11. Medically necessary magnetic resonance imagings (MRI) are covered, in accordance with accepted medical standards, for the brain, spine, knee, lower extremity, orbit or myocardium, when CT scans or SPECT procedures are not definitive or appropriate. Only one MRI per day will be paid without submission of documentation for medical necessity.

PRECERTIFICATION

Precertification for inpatient admissions must be obtained by the attending physician prior to the rendering of services. Precertification pertains to medical necessity and appropriateness of setting. Normal deliveries, services for children under twenty-one (21) years of age and recipients who have Medicare Part A are excluded from this requirement.

Approval for liver transplantation may be requested for eligible recipients with the disorders listed below. Records for all candidates for coverage will be reviewed for determination of disorder, prognosis and factors of contraindication.

End state cirrhosis with liver failure due to:

Primary biliary cirrhosis;
Primary sclerosing cholangitis;
Post necrotic cirrhosis, hepatitis B surface antigen negative;
Alcoholic cirrhosis;
Alpha-1 antitrypsin deficiency;
Wilson's disease; or
Primary hemochromatosis.

TRANSMITTAL 95-004
APPROVED 4/12/95
EFFECTIVE 1/1/95
SUPERSEDES 93-030

Organ transplant center criteria is specified in Attachment 3.1-E.

For All EPSDT Eligible Recipients:

All medically necessary diagnostic and treatment services will be provided to correct and ameliorate defects and physical and mental illnesses whether or not such services are covered or exceed the benefit limitations in the hospital program if medical necessity is properly documented and prior approval is obtained.

Non Covered Services and Procedures

1. Services and supplies which are inappropriate or medically unnecessary as determined by the Department, the Georgia Medical Care Foundation, or other authorized agent.

2. Private duty nurses or sitters/companions.

3. Take home drugs, medical supplies, durable medical equipment, artificial limbs or appliances.

4. Non-therapeutic sterilizations performed on persons under age 21 or persons who are not legally competent to give informed consent.

5. Services not medically necessary; i.e., television, telephone, guest meals, cots, etc.

6. Services or items furnished for which the hospital does not normally charge.

7. Experimental or investigational services, drugs or procedures which are not generally recognized by the Food and Drug Administration, the U. S. Public Health Service, Medicare and the Department's contracted Peer Review Organization as acceptable treatment.

   The following list is representative of non-covered procedures that are considered to be experimental or investigational and is not meant to be exhaustive:

   - Carotid body resection/carotid body denervation
   - Fetal surgery
   - Implantation of infusion pumps
   - Intestinal bypass surgery
   - Wrapping of abdominal aneurysm
   - Transvenous (catheter) pulmonary embolectomy
   - Transsexual surgery

8. Cosmetic surgery and all related services

TRANSMITTAL 93-004
APPROVED 11-4-93
EFFECTIVE 1-1-93
SUPERSEDES 92-28

POLICIES AND PROCEDURES APPLICABLE TO HOSPITAL SWING-BED SERVICES

A. The Department provides reimbursement for nursing facility services rendered in hospitals which have swing-bed agreements with Medicare under Section 1883 of the Act. Swing-beds are defined as hospital beds that may be used for either nursing facility or hospital acute levels of care on an as needed basis. All services are subject to reimbursement limitations without regard to diagnosis, type of illness or condition.

1. Covered Services

The Department covers swing-bed services only for nursing facility services. The term "nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

A physician must certify that nursing facility care is needed for continued treatment of a medical condition which cannot be managed in the home setting. The certification for nursing facility care must be obtained at the time of admission to the swing-bed, or the next working day if admitted on a weekend or holiday.

Coverage of swing-bed services involves only services in those hospitals which have Georgia Medicaid swing-bed agreements. The reimbursement rate established by the department is an all inclusive rate based on the statewide average Medicaid per diem rate paid to skilled nursing facilities and intermediate care facilities for routine services furnished during the previous calendar year. The payment rate established by the State Agency is in accordance with the requirements of Sections 1902(a)(13)(A) and 1913(a) of the Act. The rate covers the cost of the following:

(a) Patient's room and board (including special diets and special dietary supplements used for tube or oral feedings, specifically prescribed by a physician);
(b) Laundry (including personal laundry); and
(c) Nursing and routine services: Routine services, physical therapy, speech therapy, restorative nursing care, tray service, durable medical equipment (such as, but not limited to beds, bed rails, walkers, wheelchairs), incontinency care and incontinency pads, hand feedings, special mattresses and pads, massages, syringes, personal comfort or cosmetic items, extra linens, assistance in personal care and grooming, laboratory procedures not requiring laboratory personnel, non-prescription drugs (such as, but not limited to antacids, aspirin, suppositories, mild of magnesia, mineral oil, rubbing alcohol), prophylactic medications (such as, but

not limited to influenza vaccine) and other items not on the Medical Assistance Drug List but which are distributed or used individually as ordered by the attending physician. In addition, supplies (such as, but not limited to oxygen, catheters, catheter sets, drainage apparatus, intravenous solutions, administration sets and water for injections) are to be covered under the approved reimbursement rate.

Diagnostic or therapeutic x-ray services, laboratory procedures requiring laboratory personnel, physician services, and pharmacy services (except as described above) may be billed separately to the Department by the enrolled providers of service.

2. Non-Covered Services

The services listed below are non-covered by the Department in the swing-bed program. Adverse action will be taken against those providers who willfully continue to bill the Department for non-covered services identified in this manual.

a) Services which do not meet nursing facility level of care criteria;

b) Services provided by hospitals out of state which do not have a swing-bed provider agreement; and,

c) Services not provided in compliance with the provisions of the Policies and Procedures for Swing-Bed Services manual.

3. Medicaid/Medicare Services

When a Medicaid recipient also has Medicare Part A coverage, payment for swing-bed services for up to one hundred days may be allowed by Medicare. In this instance, the swing-bed services must be billed to Medicare prior to billing the Department. The Medicare intermediary reimburses for the first through the twentieth day of coverage at 100% of the Medicare per diem rate. For the twenty-first through the one hundredth day, the Medicare intermediary pays a reduced amount and Medicaid pays the applicable coinsurance amount. When Medicare Part A swing-bed benefits, i.e., skilled nursing facility care, are exhausted for these recipients, charges for days in excess of Medicare covered days may be submitted to the Department for reimbursement at the Medicaid per diem rate.

TRANSMITTAL 90-04
APPROVED 9-4-91
EFFECTIVE 1-1-90
SUPERSEDES (UP.

2.a. OUTPATIENT HOSPITAL SERVICES

Hospital outpatient coverage is provided for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished under the direction of a physician or dentist.

Limitations

1. More than one non-emergency visit by the same recipient in one day is subject to review and possible denial, depending on medical necessity.

2. Sterilizations and abortions are covered only when applicable Federal requirements are met.

3. Outpatient dialysis services are covered in the Dialysis Services program.

4. One series of birthing and parenting classes is provided per twelve-month period for pregnant women.

5. Medically necessary magnetic resonance imagings (MRI) are covered, in accordance with accepted medical standards, for the brain, spine, knee, lower extremity, orbit or myocardium, when CT scans or SPECT procedures are not definitive or appropriate. Only one MRI per day will be paid without submission of documentation for medical necessity.

Precertification

Precertification must be obtained by the attending physician for certain outpatient procedures prior to the rendering of services. Precertification pertains to medical necessity and appropriateness of setting. Services to children under twenty-one (21) years of age, emergency outpatient services, and recipients who have Medicare Part B are excluded from this requirement.

Non-Covered Services

1. Items and services which are not medically necessary for, or related to, the prevention, rehabilitation, palliative services, diagnosis or treatment of illness or injury.

2. Take-home drugs, medical supplies and appliances. (The hospital receives reimbursement for these services by enrolling as a provider of the specific service.)

3. Routine physical examinations are a non-covered service because 10% or less of the hospitals in Georgia offer routine physical examinations as a service.

4. Cosmetic surgery or mammoplasties for aesthetic purposes.

5. Services or items furnished for which the hospital does not normally charge.

6. Experimental services or procedures or those which are not recognized by the profession or the U. S. Public Health Service as universally accepted treatment.

TRANSMITTAL 95-003
APPROVED 4/12/95
EFFECTIVE 1/1/95
SUPERSEDES 93-030

2.b. RURAL HEALTH CLINIC SERVICES

Limitations

Services are subject to retrospective reduction or denial if adequate medical justification is not provided in medical records. Other ambulatory services such as dental, pharmacy, EPSDT, etc., are subject to limitations specific to the individual program.

Non-Covered Services

1. Ancillary services unrelated to the establishment of a diagnosis or treatment of the patient.

2. Routine physical examination or immunization unless in conjunction with the EPSDT Program.

3. Experimental services or procedures or those not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.

2.c. FEDERALLY QUALIFIED HEALTH CENTERS (COMMUNITY HEALTH CENTER SERVICES (CHCS))

Limitations

Services are subject to retrospective reduction or denial if adequate medical justification is not provided in medical records. Other ambulatory services such as dental, pharmacy, EPSDT, etc., are subject to limitations specific to the individual program.

Non-Covered Services

1. Ancillary services unrelated to the establishment of a diagnosis or treatment of the patient.

2. Routine physical examination or immunization unless in conjunction with the EPSDT Program.

3. Experimental services or procedures or those not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.

3. OTHER LABORATORY AND X-RAY SERVICES as prescribed in 42 CFR 440.30.

Non-Covered Services

1. X-ray services furnished by a portable x-ray service.

2. Services provided in laboratories or x-ray facilities which do not meet the definition of an independent laboratory or x-ray facility.

3. Services or procedures referred to another testing facility.

4. Services furnished by a state or public laboratory.

TRANSMITTAL 90-20
APPROVED 7-11-90
EFFECTIVE 4-1-90
supersedes 89-30

5. Services or procedures performed by a facility not certified to perform them.

6. Experimental services or procedures or those which are not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.

10-1-89 7. Laboratory services that are routinely furnished and included in the reimbursement for hemodialysis services.

TRANSMITTAL 90-20
APPROVED 7-11-90
EFFECTIVE 4-1-90
SUPERSEDES (NEW)
Received: 6/13/90

4.a. Nursing facilities provide nursing or rehabilitative care on a daily basis. Covered services include room and board (including special diets and special dietary supplements used for tube or oral feedings, when specifically prescribed by a physician), laundry (including personal laundry), nursing services (except private duty nurses), medical social services, physical therapy, speech therapy, restorative nursing care, tray service, durable medical equipment, incontinency care and incontinency pads, hand feedings, special mattresses and pads, massages, syringes, enemas, dressings, laboratory procedures not requiring laboratory personnel, non-prescription drugs such as, antacids, aspirin, suppositories, magnesium hydroxide liquid, mineral oil, rubbing alcohol, prophylactic medications, oxygen, catheters, catheter sets, drainage apparatus, intravenous solutions, administration sets and water for injections. Personal comfort or cosmetic items are not covered.

Adjunctive services (those not included in the established reimbursement rate) are covered only on written authorization in the plan of care by the attending physician. Drugs included on the Medical Assistance Drug List or those specially approved by the Department are available through the Pharmacy Services Program.

Pre-admission approval as to level of care must be obtained from the Georgia Medical Care Foundation in writing or by telephone.

Voluntary supplementation may be paid directly to providers by relatives or other persons for the additional cost of a private room and/or sitter for Title XIX recipients in nursing homes (Ga. Act. 1323). These supplemental payments are not considered as income when determining the amount of patient liability toward vendor payments. Provision of a private room and/or sitter through supplemental payment will not constitute discrimination against other recipients. No recipient who is admitted/transferred to a private room due to a shortage of beds in semi-private rooms may be discharged due to lack of voluntary supplementation. Charges for private rooms may not exceed rates charged to private patients.

4.b. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

In administering the EPSDT Program, the Department has established procedures to (1) inform AFDC families of the availability of EPSDT services; (2) provide or arrange for requested screening services; and (3) arrange for corrective treatment of health problems found as a result of screening.

EPSDT services are available through state health departments, rural health clinics, and a variety of individual practitioners both in single and group practice.